SHERYL R. MENKES, ESQ.
325 BROADWAY, Suite 504
NEW YORK, NEW YORK 10007
TEL. NO.: (212) 285-0900

The Undersigned residing at 5 West 91 st 2H NY, NY 10024

hereby retains you to prosecute or adjust a claim for damages arising from personal injuries sustained by Ronald Brophy

loss of services of _____

property damage to _____

on the _____ *day of* _____ *20*____ *through the negligence of* _____

_____

or other persons, and the undersigned hereby gives you the exclusive right to take all legal steps to enforce the said claim and hereby further agrees not to settle this action in any manner without your written consent.

In consideration of the services rendered and to be rendered by you, the undersigned hereby agrees to pay you and you are authorized to retain out of any moneys that may come into your hands by reason of the above claim:

Thirty three and one-third (33 1/3) percent, of the sum covered, whether recovered by suit, settlement or otherwise.

Such percentage shall be computed on the net sum recovered after deducting from the amount recovered expenses and disbursements for expert testimony and investigative or other services properly chargeable to the enforcement of the claim or prosecution of the action. In computing the fee, the costs as taxed, including interest upon judgment, shall be deemed part of the amount recovered. For the following or similar items there shall be no deduction in computing such percentages: liens, assignments or claims in favor of hospitals, for medical cared and treatment by doctors and nurses, or self-insurers or insurance carriers.

SHERYL R. MENKES, ESQ., as attorney, shall have the right to retain and engage other counsel as trial counsel if they deem it advisable in the best interest of the client and also investigators and other qualified professionals and other assistants where they deem same necessary. This retainer is for services rendered through trial and post-trial motions only. Should an appeal result or be required, at any stage of the litigation, an additional retainer agreement may be offered, providing for additional attorney's fees and disbursements. Sheryl R. Menkes, Esq., is not, however, obligated to pursue an appeal of an adverse court ruling. Additional services such as appeals, lien negotiations and/or legal proceedings concerning liens are not part of this retainer agreement and such services are subject to a separate retainer to be determined between the client and the attorney, and may require payment of additional legal fees.

SUBJECT TO INVESTIGATION

Dated 7/2/10

Witness Sheryl Nes

Elaine Linda Zang (L.S.)

_____ (L.S.)
Signatures

EXHIBIT D

SHERYL R. MENKES
ATTORNEY AT LAW

319 Broadway
4th Floor
New York, NY 10007

(212) 285-0900
FAX (212) 658-9408

July 23, 2010

Holy Family Home
Medical Records Department
1740 84th Street
Brooklyn, New York 11214

RE: Ronald Brophy
DOB 12/20/31
SS#: 111-26-4906
Dates of Treatment 3/25/10-5/24/10; 5/27/10-6/6/10
Date of Death 6/13/10/

ar Sir or Madam:

We have been retained by Elaine Garvy, daughter of Ronald Brophy, to investigate claims of nursing home abuse and neglect that occurred to Ronald Brophy when he was a resident at your facility.

In order to protect our client's interests it is necessary for you to provide us with the full and complete records of treatment from 3/25/10-5/24/10 and 5/27/10-6/6/10, without any omissions.

PURSUANT TO NY PUBLIC HEALTH LAW SECTION 18-1(g) and 18-2(a) a qualified person can obtain a copy of a decedent's medical records. A distributee such as Elaine Garvy is a qualified person. Accordingly, enclosed please find a duly executed authorization for the release of Mr. Brophy's medical records as well as a copy of his death certificate.

Please do not delay in your response to this request because such a delay will be highly prejudicial to our client's rights and, in some instances, result in the total loss of those rights.

Very truly yours,

Sheryl R. Menkes

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Ronald Brophy Med Rec# 030077 Bed# 4-410	12/20/31	111-26-4906

Patient Address: Holy Family Home 1740 84th St Bklyn NY 11214 Home: 260 64th Ave Bklyn 11220

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form in accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

7. Name and address of health provider or entity to release this information: Holy Family Home 1740 84th St Bklyn NY 11214

8. Name and address of person(s), or category of person to whom this information will be sent: Sheryl R Menkes Attorney 319 Broadway Cl 77 NYC 10007

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

DOS 3/25/107 5/27/10 → 6/16/10

Include: (Indicate by initialing)

_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

Authorization to Discuss Health Information

(b) ☐ By initialing here EA (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☒ Other: LITIGATION	7/23/11
12. If not the patient, name of person signing form: Elaine Garvey	13. Authority to sign on behalf of patient: Daughter Discharge

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Elaine Garvey
Signature of patient or representative authorized by law.

Date: 7/23/10

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

EXHIBIT E

SHERYL R. MENKES
ATTORNEY AT LAW

319 Broadway
4th Floor
New York, NY 10007

(212) 285-0900
FAX (212) 658-9408

September 21, 2010

St, Vincent's Catholic Medical Center
153 West 11th Street
New York New York 10011
Attn: Medical Records

RE: Ronald Brophy
DOB 12/20/31
SS#: 111-26-4906
Dates of Treatment Holy Family Home 3/25/10-5/24/10;
Date of Death 6/13/10

Dear Sir or Madam:

We have been retained by Elaine Garvy, daughter of Ronald Brophy, to investigate claims of nursing home abuse and neglect that occurred to Ronald Brophy when he was a resident at Holy Family Home on the above dates.

We have been advised that Holy Family Home Medical Records are being retained by St. Vincent's Catholic Medical Center.

In order to protect our client's interests it is necessary for you to provide us with the full and complete records of treatment from **3/25/10-5/24/10 and 5/27/10-6/6/10**, without any omissions.

PURSUANT TO NY PUBLIC HEALTH LAW SECTION 18-1(g) and 18-2(a) a qualified person can obtain a copy of a decedent's medical records. A distributee such as Elaine Garvy is a qualified person. Accordingly, enclosed please find a duly executed authorization for the release of Mr. Brophy's medical records as well as a copy of his death certificate.

Please do not delay in your response to this request because such a delay will be highly prejudicial to our client's rights and, in some instances, result in the total loss of those rights.

Very truly yours,

Sheryl R. Menkes

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

(This form has been approved by the New York State Department of Health)

Patient Name	Date of Birth	Social Security Number
ROMAN BROPHY med Rec# 038077 4410	12/20/31	111-26-4906

Patient Address: Holy Family Home 1740 86th St Bklyn NY 11214

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

7. Name and address of health provider or entity to release this information:
St Vincents Catholic Medical Center 153 W 11th St NYC 10011

8. Name and address of person(s), or category of person to whom this information will be sent:
Sheryl Menko Attorney 319 Broad Way 9th Floor NY 10007

9(a). Specific information to be released:

☒ Medical Record from (insert date) 3/27/10 to (insert date) 5/24/10
5/27/10 → 6/16/10

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

Include: (Indicate by initialing)

_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

Authorization to Discuss Health Information

(b) ☒ By initialing here BH (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☒ Other: LITIGATION	9/21/11
12. If not the patient, name of person signing form: Laine Garvey	13. Authority to sign on behalf of patient: Distributee Daughter

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Laine Garvey
Signature of patient or representative authorized by law.

Date: 9/21/10

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information [illegible]

SHERYL R. MENKES
ATTORNEY AT LAW

319 Broadway
4th Floor
New York, NY 10007

(212) 285-0900
FAX (212) 658-9408

October 18,2010

St, Vincent's Catholic Medical Center
153 West 11th Street
New York New York 10011
Attn: Medical Records

SECOND REQUEST

RE: Ronald Brophy
DOB 12/20/31
SS#: 111-26-4906
Dates of Treatment Holy Family Home 3/25/10-5/24/10;
Date of Death 6/13/10

Dear Sir or Madam:

We have been retained by Elaine Garvy, daughter of Ronald Brophy, to investigate claims of nursing home abuse and neglect that occurred to Ronald Brophy when he was a resident at Holy Family Home on the above dates.

We have been advised that Holy Family Home Medical Records are being retained by St. Vincent's Catholic Medical Center.

In order to protect our client's interests it is necessary for you to provide us with the full and complete records of treatment from **3/25/10-5/24/10 and 5/27/10-6/6/10**, without any omissions.

PURSUANT TO NY PUBLIC HEALTH LAW SECTION 18-1(g) and 18-2(a) a qualified person can obtain a copy of a decedent's medical records. A distributee such as Elaine Garvy is a qualified person. Accordingly, enclosed please find a duly executed authorization for the release of Mr. Brophy's medical records as well as a copy of his death certificate.

Please do not delay in your response to this request because such a delay will be highly prejudicial to our client's rights and, in some instances, result in the total loss of those rights.

Very truly yours,

Sheryl R. Menkes

OCA Official Form No. 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
RONALD BROPHY 03077 14-410 Med Rec #	12/20/31	111-26-4906
Patient Address: Holy Family Home 1740 84th St Bklyn NY 11214 Home Address 2606 5th St Bklyn NY 11226		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth below on this form.

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 3), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

7. Name and address of health provider or entity to release this information:
St Vincents Medical Center 153 W. 11th St NYC 10011

8. Name and address of person(s) or category of person to whom this information will be sent:
Sheryl Menkes 319 Broadway Ltd NYC 10007

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

DOS: 3/25/10 – 5/24/10 EG
5/27/10 – 6/16/10 EG

Include: (Indicate by initialing)
EG Alcohol/Drug Treatment
EG Mental Health Information
EG HIV-Related Information

Authorization to Discuss Health Information

(b) ☐ By initialing here EG (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☒ Other: LITIGATION	10/18/11
12. If not the patient, name of person signing form: Elaine Garvey	13. Authority to sign on behalf of patient: Distribute

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Elaine Garvey
Signature of patient or representative authorized by law.

Date: 10/18/10

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

EXHIBIT F

Ackerman Court Servi...

KINGS COUNTY CLERK
RECEIVED
2013 JAN -4 PM 3:07

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS

----------X

ELAINE GARVEY, as administratrix of the Estate of RONALD BROPHY, deceased,

Plaintiff,

-against-

LUTHERAN MEDICAL CENTER, METROPOLITAN JEWISH HOME CARE, INC., METROPOLITAN JEWISH LONG TERM HOME CARE, METROPOLITAN JEWISH LHCSA, HOMEFIRST LHCSA, INC., LUTHERAN AUGUSTANA CENTER FOR EXTENDED CARE AND REHABILITATION, INC., HOLY FAMILY HOME, ST. VINCENT'S CATHOLIC MEDICAL CENTERS OF NEW YORK a/k/a SAINT VINCENT CATHOLIC MEDICAL CENTERS a/k/a SVCMC-ST VINCENTS MANHATTAN, BENSONHURST CENTER FOR REHABILITATION AND HEALTHCARE and KFG OPERATING TWO, LLC,

Defendants.

----------X

Index Number 218 - 2013
Date Filed 1-4-2013

Plaintiff designates KINGS County as place of trial.
The basis of venue is plaintiff's residence.

SUMMONS WITH NOTICE

To the above named Defendants:

You are hereby summoned to answer the complaint in this action and to serve a copy of your answer, or, if the complaint is not served with this summons, to serve a notice of appearance, on the Plaintiff's Attorney within twenty (20) days after the service of this summons, exclusive of the day of service (or within 30 days after the service is complete if this summons is not personally delivered to you within the State of New York); and in case of your failure to appear or answer, judgment will be taken against you by default for the relief demanded herein.

Dated: New York, New York
January 3, 2013

Sheryl R. Menkes
Attorney for Plaintiff
325 Broadway, Suite 504
New York, New York 10007
212-285-0900

Upon your failure to appear, judgment will be taken against you by default for the sum of TEN MILLION ($10,000,000.00) DOLLARS with interest from January 3, 2013 and the costs of this action.

Notice: The nature of this action is Negligence, Gross Negligence, Nursing Home Abuse. The relief sough is monetary, compensatory, and punitive.

Defendants Address:

Lutheran Medical Center
150 55th Street
Brooklyn, NY 11220

Metropolitan Jewish Home Care, Inc.
440 Ninth Avenue, 14th Floor
New York, NY 10001

Metropolitan Jewish Home Care, Inc.
6323 Seventh Avenue
Brooklyn, NY 11220

Metropolitan Jewish Long Term Home Care
6405 Seventh Avenue
Brooklyn, NY 11220

Metropolitan Jewish LHCSA
6323 7th Avenue
Brooklyn, NY 11220

Homefirst LHCSA, Inc.
6323 Seventh Avenue
Brooklyn, NY 11220

Lutheran Augustana Center for Extended Care & Rehabilitation, Inc.
5434 Second Avenue
Brooklyn, NY 11220

Holy Family Home
450 West 33rd Street
Mezzanine Level
New York, NY 10001

St. Vincent's Catholic Medical Centers of New York
450 West 33rd Street
Mezzanine Level
New York, NY 10001

Saint Vincent Catholic Medical Centers
450 West 33rd Street
Mezzanine Level
New York, NY 10001

SVCMC-St. Vincents Manhattan
450 West 33rd Street
Mezzanine Level
New York, NY 10001

Bensonhurst Center for Rehabilitation and Healthcare
1740 84th Street
Brooklyn, NY 11214

KFG Operating Two, LLC
1740 84th Street
Brooklyn, NY 11214

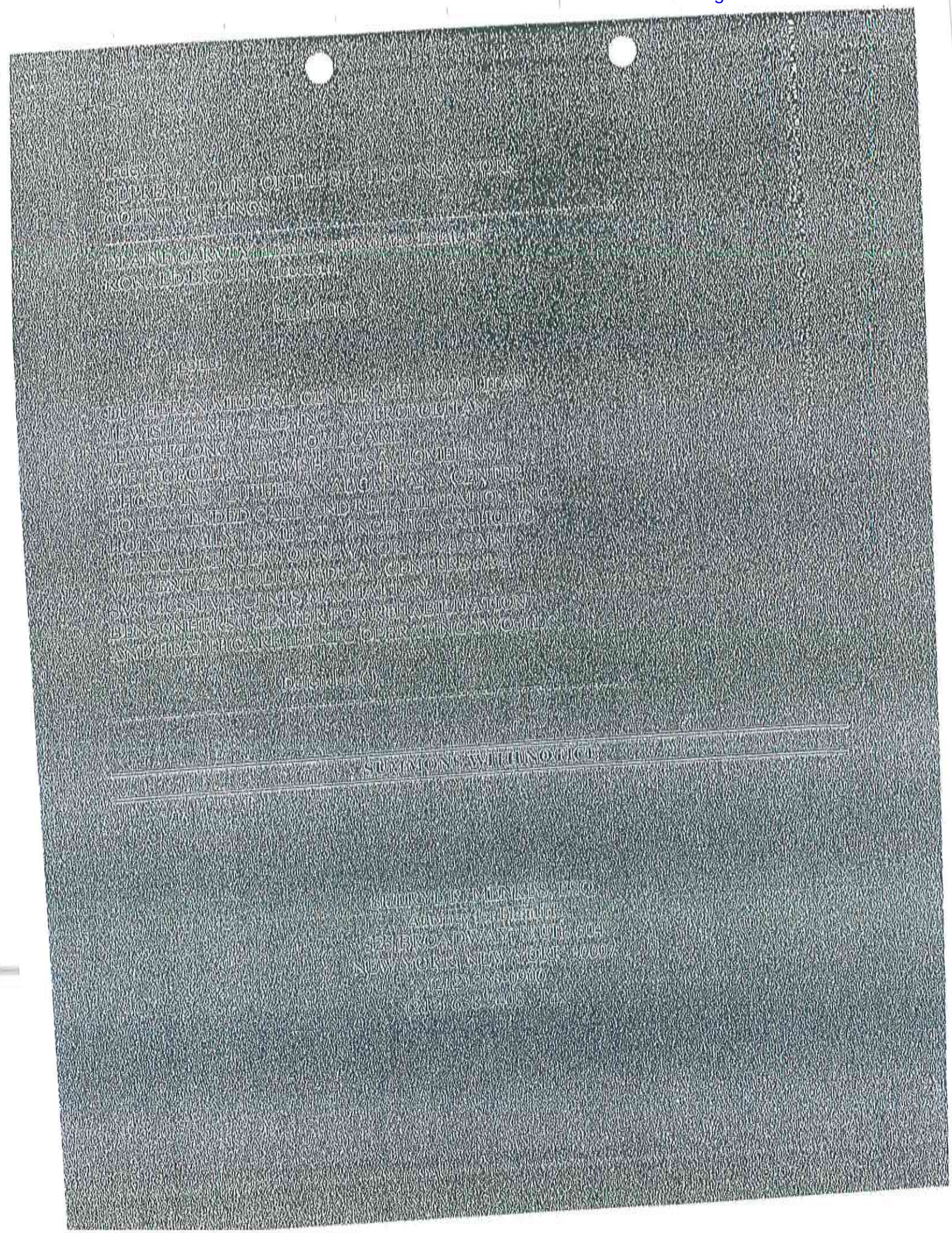

EXHIBIT R

Notice of Affidavit of Sheryl R. Menkes, Notice of Affidavit of Accountant for Sheryl R. Menkes and 2010 2011 Tax Returns, Profit and Loss Statements, etc.

(TAX RETURNS AND PROFIT AND LOSS STATEMENTS INCLUDED IN COURT COPY ONLY)